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C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations.

12 VAC 30-70-380. Repealed.

12 VAC 30-70-381. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding the standardized operating costs.

3. The average standardized cost per DRG shall be calculated by dividing the standardized operating costs for all groupable cases in the DRG by the number of groupable cases classified in the DRG.

4. The average standardized cost per case shall be calculated by dividing the standardized operating costs for all groupable cases by the total number of groupable cases.

5. The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

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D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-390. Repealed.

12 VAC 30-70-391. Recalibration and rebasing policy.

The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three year. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

Article 3.
Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This section shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY 1997. This adjustment incorporates in per diem rates the systemwide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

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2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology 12 VAC 30-70-351.

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

5. This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6. This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the prospective payment methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used shall be determined on the basis of cost report and other applicable data from the most recent year for which reliable data are available at the time of rebasing.

12 VAC 30-70-420. Reimbursement of noncost-reporting general acute care hospital providers.

Effective July 1, 2000, noncost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

Prior approval must be received from DMAS when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

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12 VAC 30-70-435. Lump sum payment.
In addition to the DRG payment, DMAS shall make a one-time, lump sum payment of $12,243,204 to eligible Virginia hospitals participating in the Medicaid program. This payment shall be made in two equal, semi-annual amounts during fiscal year 2001. For purposes of distribution, each hospital's share of the total amount shall be determined as follows:

a. DMAS shall determine the total operating payments due each hospital for inpatient hospital services provided from January 1, 2000, through June 30, 2000, using hospital claims data from discharges in that period.

b. DMAS shall determine the total operating payments that would have been due each hospital for the same services, had the inpatient hospital rates and weights applicable in fiscal year 1998 been continued with inflation for fiscal years 1999 and 2000.

c. The difference between the two values calculated in (i) and (ii) above, summed across all hospitals, is the "statewide difference." Each hospital-specific difference divided by the statewide difference is the hospital-specific percent share of the statewide difference.

d. The hospital-specific percent share of the statewide difference, times the total funds provided by this appropriation, is the hospital-specific lump sum payment to be paid in two equal semi-annual payments during fiscal year 2001. This payment shall be made as an increase to reimbursement for services provided to Medicaid recipients during state fiscal year 2001. For each hospital, the hospital-specific lump sum payment amount shall be divided by the number of DRG cases in the hospital discharged from July 1, 2000, through December 31, 2000, on or before April 30, 2001. This per case amount shall be paid to each hospital for each of the cases discharged by the hospital during this specified time period, as determined by DMAS.

2. The Department of Medical Assistance Services shall provide the data used, specific calculation, and mechanics of the payment adjustment to the Virginia Medicaid Hospital Policy Advisory Council.

12 VAC 30-70-440. Repealed.

12 VAC 30-70-450. Cost reporting requirements.

Except for non-cost-reporting general acute care hospitals and freestanding psychiatric facilities licensed as hospitals, all hospitals shall submit cost reports. All cost reports shall be submitted on uniform reporting forms provided by the state agency and by Medicare. Such cost reports shall cover a 12-month period. Any exceptions must be approved by the state agency. The cost reports are due not later than 150 days after the provider's fiscal year end. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the program shall take action in accordance with its policies to ensure that an overpayment is not being made. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. The reductions shall start on the first day of the following month when the cost report is due. After

the delinquent cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to the state agency. The cost report will be judged complete when the state agency has all of the following:

1. Completed cost reporting form or forms provided by DMAS, with signed certification or certifications.

2. The provider's trial balance showing adjusting journal entries.

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of changes in financial position, and footnotes to the financial statements. Multi-level facilities shall be governed by subdivision 5 of this subsection.

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report.

5. Hospitals which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report, and footnotes to the financial statements;

c. The hospital's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value.

6. Such other analytical information or supporting documents requested by the state agency when the cost reporting forms are sent to the provider.

12 VAC 30-70-460. Hospital settlement.

A. During the transition period claims will be processed and tentative payment made using per diem rates. Settlements will be carried out to ensure that the correct blend of DRG and per diem-based payment is received by each general acute care and rehabilitation hospital and to settle reimbursement of pass-through costs. There shall be no settlement of freestanding psychiatric facilities licensed as hospitals except with respect to disproportionate share hospital (DSH) payment, if necessary (see 12 VAC 30-70-301 E).

B. The transition blend percentages which determine the share of DRG system and of revised per diem system reimbursement that is applicable in a given period shall change with the change of the state fiscal year, not the hospital fiscal year.

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C. If a hospital's fiscal year does not end June 30, its first year ending after June 30, 1996, contains one or more months under the previous methodology, a "split" settlement shall be done of that hospital's fiscal year. Services rendered through June 30, 1996, shall be reimbursed under the previous reimbursement methodology and services rendered after June 30, 1996, will be reimbursed as described in subsection G of this section.

D. For cases subject to settlement under the blend of DRG and per diem methodologies (cases with an admission date after June 30, 1996), the date of discharge determines the year in which any inpatient service or claim related to the case shall be settled. This shall be true for both the DRG and the per diem portions of settlement. Interim claims tentatively paid in one hospital fiscal year that relate to a discharge in a later hospital fiscal year, shall be voided and reprocessed in the latter year so that the interim claim shall not be included in the settlement of the first year, but in the settlement of the year of discharge. An exception to this shall be rehabilitation cases, the claims for which shall be settled in the year of the "through" date of the claim.

E. A single group of cases with discharges in the appropriate time period shall be the basis of both the DRG and the per diem portion of settlement. These cases shall be based on claims submitted and, if necessary corrected by 120 days after the providers FYE. Cases which are based on claims that lack sufficient information to support grouping to a DRG category, and which the hospital cannot correct, shall be settled for purposes of the DRG portion of settlement based on the lowest of the DRG weights.

F. Reimbursement for services in freestanding psychiatric facilities licensed as hospitals shall not be subject to settlement.

G. During the transition period settlements shall be carried out according to the following formulas.

1. Settlement of a hospital's first fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Paid days occurring in the hospital's fiscal year before July 1, 1996, times the per diem in effect before July 1, 1996.

(2) Paid days occurring after June 30, 1996, but in the hospital fiscal year, that are related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective on July 1, 1996.

(3) DRG system payment for DRG and psychiatric cases admitted after June 30, 1996, and discharged within the hospital fiscal year times 1/3.

(4) DRG system payment for rehabilitation claims having a "from" date of July 1, 1996, or later and a "through" date within the hospital fiscal year times 1/3.

(5) Paid days from the cases and claims in subdivisions 1 a (3) and (4) of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

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b. DSH reimbursement shall be equal to paid days from the start of the hospital fiscal year through June 30, 1996, times the DSH per diem effective before July 1, 1996. There shall be no settlement of DSH after July 1, 1996, as the lump sum amount shall be final.

c. Pass-throughs shall be settled as previously based on allowable cost related to days paid in subdivisions 1 a (1), (2), and (5) of this subsection.

2. Settlement of a hospital's second fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Days occurring in the hospital fiscal year related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective at the time.

(2) DRG system payment for DRG and psychiatric cases discharged in the hospital fiscal year, but before July 1, 1997, times 1/3.

(3) DRG system payment for rehabilitation claims having a "through" date within the hospital fiscal year but before July 1, 1997, times 1/3.

(4) Covered days from the cases and claims and in subdivisions 2 b and c of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

(5) DRG system payment for DRG and psychiatric cases discharged from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(6) DRG system payment for rehabilitation claims having a "through" date from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(7) Covered days from the cases and claims and in subdivisions 2 a (5) and (6) of this subsection, times the revised system per diem that is effective on July 1, 1997, times 1/3.

b. DSH reimbursement shall be the predetermined lump sum amount.

c. Pass-throughs shall be settled as previously, based on allowable cost related to days paid in subdivisions 2 a (1), (4), and (7) of this subsection.

12 VAC 30-70-470. Underpayments.

When the settlement of a hospital fiscal year indicates that an underpayment has occurred, the state agency shall pay the additional amount to the hospital within 60 days of completion of the settlement.

12 VAC 30-70-480. Refund of overpayments.

A. Lump sum payment. When the settlement of a hospital fiscal year indicates that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where the state agency discovers an overpayment during desk review, field audit, or final settlement, the state agency shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken unless the hospital disputes the state agency's determination of the overpayment. If the hospital disputes the state agency 's determination, recovery, if any, shall be undertaken after the issue date of any administrative decision issued by the state agency after an informal fact finding conference.

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B. Offset. If the hospital has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the hospital has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the hospital cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the hospital shall request an extended repayment schedule at the time of filing or (ii) within 30 days after receiving the DMAS demand letter, the hospital shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a hospital demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the director) may approve a repayment schedule of up to 36 months.

A hospital shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the hospital submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the hospital withdraws from the program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the hospital or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the hospital shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the hospital written notification of the approved repayment schedule, which shall be effective retroactive to the date the hospital submitted the proposal.

E. Interest charge on extended repayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the hospital indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the hospital does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, regardless of whether the hospital files a further appeal. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the hospital shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the hospital paid to DMAS.

12 VAC 30-70-490. Medicaid Hospital Payment Policy Advisory Council.

In order to ensure the ongoing relevance and fairness of the prospective payment system for hospital services, the Director of the Department of Medical Assistance Services shall appoint a Medicaid Hospital Payment Policy Advisory Council. The council shall be composed of four hospital or health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior

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department staff and one representative each from the Department of Planning and Budget and the Joint Commission on Healthcare. This council will be charged with evaluating and developing recommendations on payment policy changes in areas that include, but are not limited to, the following: (i) utilization reductions directly attributable to the 1995 Appropriations Act utilization initiative and any necessary adjustments to SFY1997 and 1998 DRG rates; (ii) the update and inflation factors to apply to the various components of the delivery system; (iii) the treatment of capital and medical education costs; (iv) the mechanisms and budget implications of recalibration and rebasing approaches; (v) the disproportionate share payment fund and allocation mechanisms; and (vi) the timing and final design of an outpatient payment methodology.

12 VAC 30-70-499. Reserved.